US Decisions Inc.

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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW: May/31/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Repeat MRI left shoulder

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Orthopedic Surgeon

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
Official Disability Guidelines
Request for IRO dated 05/18/12
Utilization review determination dated 04/12/12
Utilization review determination dated 05/17/12
Physical therapy treatment records, 10/9/11, 9/22/11
Work hardening program progress notes, Week ending 2/10/11, 1/19/12, Week ending 3/212
Functional capacity evaluation dated 01/19/12
MRI left shoulder dated 08/24/11
Clinical records Dr. dated 08/31/11-05/18/12
Operative report dated 09/13/11
Clinic note Dr. 03/23/12

PATIENT CLINICAL HISTORY SUMMARY
The claimant is a male who is reported to have sustained an injury to his left shoulder on xx/xx/xx. On this date a barrel fell on his left arm as he was taking out a big tube and he heard his left shoulder pop. He was seen at Medical Center where x-rays were taken. He was given medications and referred for physical therapy. He ultimately underwent MRI and was taken to surgery on 09/13/11. At this time Dr. performed left shoulder proximal biceps tenodesis, diagnostic arthroscopy and debridement. Postoperatively the claimant had uncomplicated course and was referred for physical therapy. On 11/02/11 the claimant is noted to have increasing pain. There is warmth and tenderness to palpation and slightly more red than the other side. There is recommendation for I&D. When seen in follow-up on 11/21/11 the incision is reported to have calmed down without signs of infection. He received corticosteroid injection at this visit and undersurface of left shoulder biceps tendon groove. On 12/21/11 the claimant was seen in follow-up. He is reported to have limitations in range of motion, positive Neer and Hawkins impingement signs, pain with rotation, and opined to be

developing frozen shoulder. He was recommended to have aggressive range of motion exercises and physical therapy. He was recommended to participate in work hardening program. On 03/07/12 the claimant is reported to have continued pain. He continues to have limited range of motion. He received injections into subacromial and glenohumeral joint. On 03/23/12 the claimant was seen by Dr.. On physical examination he has active elevation to 110 degrees, passive elevation to 120 with complaints of pain. He has some deformity of biceps muscle. There is recommendation for repeat imaging. On 04/06/12 the claimant was seen in follow-up by Dr.. He is noted to have continued limitations in range of motion of shoulder. Most recent note is dated 05/18/12. He is 8 months status post surgery with continued complaints, continued limitations in range of motion. He is recommended to undergo MRI of shoulder.

The initial request was reviewed by Dr. on 04/12/12. Dr. non-certified the request. He notes the claimant's examination is not changed, and the claimant is noted to have physical examination findings including decreased strength, decreased range of motion in shoulder. He reported it does not appear as if there have been significant lower levels of care other than postoperative physical therapy and work hardening. He reports there does not appear to have been attempted shoulder injection to see if improvement in symptoms can be made. A subsequent appeal request was reviewed on 05/17/12 by Dr.. Dr. opines that review of applicable records indicates no significant change in symptoms or findings suggestive of significant pathology and therefore repeat MRI is not clinically indicated.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

The submitted clinical records indicate the claimant is status post left shoulder surgery performed on 09/13/11. Postoperatively the claimant has undergone extensive course of conservative treatment consisting of oral medications, physical therapy, and multiple corticosteroid injections. The claimant has made no substantive improvement in postoperative period. This claimant is noted to have developed signs and symptoms of adhesive capsulitis. Further, he is noted to have significant limitations in range of motion. However, the ODG states "Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and /or findings of significant pathology." The guidelines have not been met in this instance. The reviewer finds no medical necessity for Repeat MRI left shoulder.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)